Law and the Public's Health

WHEN WORLDS COLLIDE: PUBLIC HEALTH AND UNION RIGHTS IN *VIRGINIA MASON HOSPITAL V WASHINGTON STATE NURSES ASSOCIATION*

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This installment of *Law and the Public's Health* reports on *Virginia Mason Hospital v Washington State Nurses Association*,[1] a case that illustrates what happens under the law when public health policy imperatives are expressed in vague and ambiguous terms rather than as explicit regulatory standards governing private conduct. In this case, the private conduct in question involved a collective bargaining agreement (CBA); the decision underscores the degree of deference that the law gives to such agreements even in matters of public health safety, in the absence of legal requirements to the contrary, and regardless of the strength of the evidence that supports the underlying public health policy.

Following an overview of the decision, the column considers its implications for public health policy and practice.

THE *VIRGINIA MASON* DECISION

Background

The case arose when Virginia Mason Hospital, a 336-bed acute care hospital in Seattle, Washington, made mandatory a previously voluntary employee influenza immunization program. In 1998, the hospital had instituted an immunization program on a voluntary basis; free immunizations were made accessible through a mobile cart that moved through "nursing stations, the hospital cafeteria, staff meetings, and other locations."[1] Despite these efforts, employee immunization rates stood at 55% after six years.

In September 2004, the hospital made the program mandatory, sending a memorandum to all staff stating that "except in cases of a religious objection or documented vaccine allergy," annual proof of flu vaccination would be a "'fitness for duty' requirement . . ." Employees who could not show proof of vaccination by January 1, 2005, would "'face termination' unless he or she agreed to take flu prophylaxis medication at his or her own expense."[1] The Board of Trustees approved the mandatory vaccination policy in November 2004. According to uncontroverted evidence presented at trial, the purpose of the mandate was to protect the hospital's disproportionately elderly and frail Medicare patients.

The Washington State Nurses Association (WSNA), which represented the nurses, filed a labor grievance about the compulsory policy, recognizing immunizations as a good choice but "just that—a choice." A labor arbitrator upheld the grievance and ordered the policy suspended. The basis for the arbitrator's ruling was that the CBA required negotiations for any job requirement that was an initial or ongoing "condition of employment," a term that applied to the immunization requirement once it became compulsory. The arbitrator further held that the CBA's management rights clause, which allowed certain management changes without bargaining, covered only operational decisions and not requirements that directly affected conditions of employment.[1] Furthermore, the arbitrator concluded, despite the existence of a so-called zipper clause that prevents claims of collective bargaining over any matter not expressly set forth in the agreement, the fact that workforce immunization was not specifically mentioned was irrelevant, because the requirement was in fact a condition of employment for which the nurses could bargain and grieve.

The hospital appealed the ruling. The federal district court that initially reviewed the decision upheld the arbitrator, finding his interpretation of the CBA plausible. The court also found that the hospital "did not show any explicit, well-defined, and dominant public policy that was contravened by the arbitrator's decision."[1] The hospital then appealed to the U.S. Court of Appeals for the 9th Circuit. (The WSNA cross-appealed the court's denial of its motion for attorneys' fees because of the absence of bad faith on the part of the hospital—the standard that must be met before a union can recover expenses related to a grievance.)

THE COURT OF APPEALS DECISION

The court affirmed the arbitrator's decision, opening its opinion by recognizing the hospital's "commendable desire to protect its vulnerable patients from infection from the flu" as well as "the impressive list of health authorities and experts" that recommends immunization of the health-care workforce. But, the

court noted, federal labor laws authorizing collective bargaining are designed with a strong public policy purpose in mind; namely, the advancement of private collective bargaining. Thus, grievance decisions by labor arbitrators are entitled to considerable deference and can be vacated only if the decision "fail[s] to draw its essence from the CBA itself [citations omitted] or . . . [violates] an 'explicit, well-defined, and dominant public policy.'"[1]

In arguing that the arbitrator's ruling was erroneous, the hospital pointed to three CBA provisions that it claimed permitted the imposition of its mandatory immunization policy: a patient care priority clause, a management rights clause, and the zipper clause. Noting that the decision could be vacated only if the arbitrator ignored the plain language of the contract or had "misread the contract or erred in interpreting it,"[1] the court found no evidence that the arbitrator had misread the terms of the CBA. Instead, the court concluded, the arbitrator had merely interpreted the contract in the Association's favor in light of the terms of the agreement and the facts of the case. Under labor law, labor arbitrators are given broad latitude to interpret and apply CBA clauses, and their interpretations will be set aside only if not plausible on their face.

In this case, according to the court, the facts confirmed that the hospital indeed had attempted to add a condition of employment rather than merely implement existing policies as a matter of hospital operations. In this regard, the management rights clause could not help the hospital, as this clause could not shield the hospital from liability for attempting to change terms and conditions that were fundamental to continued employment. Indeed, these were precisely the types of decisions that were classified under the CBA as covered by the obligation to collectively bargain. The court also found that although immunizations were not explicitly addressed in the CBA, the failure to specify immunizations did not alter their status as conditions of employment, which were covered by the agreement.

Undoubtedly the most interesting aspect of the case from a public health policy perspective was the court's treatment of the question as to whether there was an "explicit, well-defined, and dominant public policy" with respect to the immunization of health-care workers that, as a matter of law, trumped privately bargained union contracts. In making its public policy argument, the hospital pointed to numerous laws: state hospital licensure laws that require hospitals to "develop and implement written policies and procedures consistent with the published guidelines of the . . . [Centers for Disease Control and Prevention]";[2] federal Medicare regulations setting forth conditions of participation for hospitals[3] that mandate that participating hospitals maintain an "active program for the prevention, control, and investigation of infections and communicable diseases"; and the state's Uniform Disciplinary Act setting forth professional nursing standards that classify as a violation "[engaging] in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health."[4]

The court concluded, however, that none of these laws amounted to an "explicit, well-defined, and dominant public policy" regarding immunization of the health-care workforce. The court reasoned as follows:

> Hospitals theoretically could be liable . . . for the unprofessional conduct of their nurse employees, but [the hospital could not cite] a single example of a hospital facing legal action because a patient contracted the flu from a health care worker. Nor has [the hospital] provided any evidence of its inability, or the inability of peer institutions that do not require flu immunization of all employees, to comply with the state and federal regulatory regimes on infection control . . .[1]

In other words, said the court, the hospital could not justify immunizations as a legal liability compliance step that was designed to avert exposure to medical negligence. The hospital simply could not show any case in which hospitals had been successfully sued over their failure to prevent preventable infection.

Nor could the hospital claim that regulatory law required immunization of its workforce, because neither federal nor state law explicitly required such preventive actions. Both federal and state law simply ambiguously referred to prevention, infection control, and other policy goals without specifying any particular action on the part of hospitals in furtherance of these general policies. Given the standards' vagueness, no hospital could reasonably be subjected to the loss of its license or its Medicare participation rights; indeed, were an enforcement action to be brought against the hospital on the grounds that its workers were not immunized, the hospital in all likelihood could have successfully defended against such an action based on the standards' vagueness, given the constitutional imperative of clarity in the regulation of private rights.[5]

Simply put, legislatures and regulatory agencies know how to write binding, explicit statutory and regulatory standards. Here, none existed. As a result, the court simply would not permit one party to a CBA to unilaterally impose a change in the conditions of

employment of a unionized workforce that had bargained in good faith.

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

Three lessons can be drawn from this decision. First, U.S. law heavily favors contractual rights generally, and the favored status given private agreements is no more in evidence than in the case of U.S. labor laws. The right of the workforce to organize and collectively bargain is foundational. Even though much of the American workforce is not unionized, the concept of unionization and collective bargaining is embedded in American labor law. As a result, in the absence of strong and clear preemptive public policies to the contrary, the courts will uphold the terms of duly negotiated CBAs.

Second, public health policies cannot be stated in vague and ambiguous terms. Before courts will require private actors to alter their conduct, there must be clear and enforceable standards that prospectively guide such conduct. The mere possibility that conduct (in this case, not being immunized) may in the future harm someone is not in and of itself a legal requirement that conduct be altered. As the court pointed out when the hospital attempted to categorize its change in immunization policy as a matter of legal risk reduction, the issue of legal exposure was purely speculative and insufficient in and of itself to overcome the terms of a duly negotiated agreement. If the hospital had been so concerned about its legal risk exposure, then it could have put this issue on the table during the CBA negotiations. The hospital apparently did not do so.

Similarly, if lawmakers had really wanted to protect Medicare and other hospital patients from the risk of spread of disease by the workforce, they certainly could have written laws or regulations that imposed such standards. These standards would have trumped the CBA, as CBAs, like other contracts, must conform to public laws. Yet lawmakers chose instead to speak in code, creating a public perception of safety when, from a legal perspective, the statutes merely created a nonenforceable illusion of safeguards.

Third, and perhaps most fundamentally, is the issue of the workers' immunization status. Why were the rates so low when, as the hospital pointed out, evidence of the importance of immunization was so strong? Of great concern should be the underlying unwillingness on the part of hospital workers to be immunized, even when the hospital allegedly had made reasonable efforts to make vaccinations available and despite the public health threat created by low health-care worker immunization rates. In this regard, this decision underscores the importance of active and intensive collaboration among unions, management, and public health authorities to address matters of public health safety as a matter of basic health-care operations.

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REFERENCES

1. 511 F. 3d 908 (2007).
2. Wash. Admin. Code 246-320-265(3).
3. 42 CFR §482.42.
4. Wash. Rev. Code §18.130.180(15).
5. Gostin LO. Public health law: power, duty, restraint. Berkeley (CA): University of California Press; 2001.